Community Care of North Carolina/Carolina Access (CCNC/CA)
COMPLAINT FORM INSTRUCTIONS

CCNC/CA wants you and other members of your family who are enrolled in CCNC/CA to have good medical care. If you have problems obtaining appropriate and timely medical care, or feel that your primary care provider or office staff said and/or did something you consider inappropriate (including physical or sexual contact or provider alcohol/drug use), please complete the attached CCNC/CA complaint form.

INSTRUCTIONS FOR COMPLETING THE FRONT PAGE OF THE FORM:

Before your complaint can be addressed, please provide information that will tell us about your situation.

1. On the first two lines, print your name and the date you are filling out the form. If you are making this complaint for someone else, put your relationship to that person.
2. Print the name and date of birth (DOB) of the person on whose behalf this complaint is being made. (If you are making this complaint for yourself, put your name again.)
3. Please look at the Medicaid or NCHC card. Beside your name there is an identification number; copy that number in the "ID" blank. Put the name of the county in which you live.
4. Print your address or how we can contact you by mail. (If you have a P.O. Box, please list that number.)
5. If you have a telephone, please place the number here. If you do not have a telephone but want to put someone else's number where we may reach you, please print that person's name and number. (We will not leave a message or discuss the purpose of the call with anyone other than you, but we may want to leave a message for you to call us.)
6. Print the name of the doctor or provider against whom you wish to make the complaint. If you know the name of the practice and it is different from your provider's name, print the name of the practice on this line.
7. Write in detail what happened that caused you to want to make this complaint. It is helpful if you have people's names and the dates the events occurred. If there is any other information or documents that can support the things you are saying, please include them when you send in this form.

INSTRUCTIONS FOR COMPLETING THE SECOND PAGE OF THE FORM:

It is helpful in investigating your complaint if we have permission to use your name; however, if you do not want us to use your name, we will still investigate your complaint. It is important for you to understand that it is always more effective when we are able to use your name.

1. If you give us permission to use your name, sign here.
2. If you do not want us to use your name, sign here.

When all the information is completed, mail this form to:

ATTN: Quality Management
DMA Managed Care
2501 Mail Service Center
Raleigh, NC 27699-2501

DMA will send you a receipt confirmation letter within 7 days of receiving your complaint. Results of complaint investigations must remain confidential according to state regulations; therefore you will not be informed of the findings or decisions regarding your complaint.

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Community Care of North Carolina/Carolina Access (CCNC/CA)

COMPLAINT FORM

Note: for reporting complaints regarding CCNC/CA Providers Only

Mail the completed, *signed* form to:

DMA/Managed Care
2501 MAIL SERVICE CENTER
Raleigh, NC 27699-2501

Name of Person completing this Form: _____
(May be the CCNC/CA enrollee, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to CCNC/CA Enrollee: _____

CCNC/CA Enrollee Name: _____ DOB: _____

Medicaid or NCHC ID: _____County of Residence: _____

Address: _____

Telephone Number: _____

Name of Doctor:_____ Practice:_____

Please describe your complaint in detail including dates/names: (please attach any additional documentation)

Community Care of North Carolina/Carolina Access (CCNC/CA) Complaint Form

CCNC/CA Quality Management (QM) staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place for addressing them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **Please do not sign both statements.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the Community Care of North Carolina/Carolina Access QM staff permission to use my name when sharing my complaint with the Primary Care Provider (PCP) named in my complaint. The PCP has my permission to respond to the CCNC/CA QM staff concerning my complaint and release my/the medical records when necessary.

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

_____ _____

Signature of Complainant Date

_____ _____

Signature of Patient/Parent/Legal Guardian Date of Birth

If you have any questions regarding the use of this form or the CCNC/CA Complaint Process, please contact the DMA Managed Care office in Raleigh at 1-888-245-0179. *Thank you for giving us this opportunity to serve you better*.

Please Do Not Write Below This Line

CCNC/CA PCP Name: _____ CCNC/CA PCP#: _____

CCNC/CA Practice Name: _____

County Where CCNC/CA Practice is Located: _____

Comments: _____

N.C. Medical Board Referral Form

The North Carolina Medical Board is responsible for the licensing and discipline of physicians, nurse practitioners, physician assistants, and intermediate and advanced emergency medical technicians (referred to as licensees). If the Board finds a licensee has violated the North Carolina Medical Practice Act, the Board will take disciplinary action following due process and opportunity for a public hearing. **As part of their investigative process, the N.C. Medical Board will forward a copy of your complaint to the licensee for his/her review and response.** If the Medical Board feels that it is necessary, they will request and review medical records from any and all treating physicians or facilities and any other persons who participated in your/the patient's care. This information should include but is not limited to: patient histories, discharge summaries, operative notes, examination and test results and any reports or information prepared by other persons. The Community Care of North Carolina/Carolina Access (CCNC/CA) program has a procedure of referring complaints alleging physical/sexual/substance abuse or inappropriate behavior to the N.C. Medical Board for investigation. The CCNC/CA Quality Management staff must have your permission to refer your complaint to the N.C. Medical Board.

If you agree with the referral, please read and sign the statement below:

I give the Community Care of North Carolina/Carolina Access program permission to refer my complaint to the N.C. Medical Board. I understand that the Board will share my complaint with the licensee, and I give the licensee and any treating physicians, facilities and others involved in my/the patient's care permission to release a copy of my/the patient's medical records to the N.C. Medical Board.

Full Name of Patient (*Print)*	Date of Birth
Signature of Patient/Legally Responsible Person	Date